


ARIZONA DEPARTMENT OF HEALTH SERVICES BUREAU OF EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEM

Premier EMS Agency Program (PEAP) Application October 2012






Leadership for a Healthy Arizona


Bureau of Emergency Medical Services and Trauma System

Arizona Header



AZ.GOV
Arizona's Official Web Site

Arizona Prehospital Information and EMS Registry System (AZ-PIERS)




INTEGRATIVE CARE

AZ-PIERS is the prehospital data collection component of the Premier EMS Agency Program (PEAP), a quality assurance initiative of the Bureau of EMS and Trauma System, facilitating statewide measurable improvements in emergent patient outcomes through evidence-based patient care, quality assurance processes, training, and research.

HIPAA allows covered entities (i.e. hospitals, fire and ambulance services) to supply the necessary data to the public health authority without patient authorization (Section 164.512). AZ-PIERS is fully HIPAA compliant.

Besides quality improvement activities, data submitted to AZ-PIERS can be used by ADHS, EMS agencies, hospitals, and learning institutions to advocate for resources, prepare grants, and other system




SYSTEM LOGIN

Username:

Password:

[CLICK HERE IF YOU FORGOT YOUR PASSWORD](#)



Central Region
Northern Region
Southeastern Region
Western Region



Bureau of Emergency Medical Services and Trauma System PEAP EMS Agency Application

Please provide all requested information using black or blue ink only. You may type or handwrite your responses

Section A. Agency Information

1	Agency Name	
2	Business Address	
3	Phone Number	
4	E-Mail Address	

Section B. Agency Service

1	Service Level	BLS <input type="checkbox"/> ALS <input type="checkbox"/> BOTH <input type="checkbox"/>
2	Number of EMS Runs/Yr	BLS: Transp. , Non-Transp. , ALS: Transp. , Non-Transp.

Section C. Agency Administration

1	Chief Administrator Name	
2	Phone Number	
3	E-Mail Address	

1	Admin. Medical Director Name(If Applicable)	
2	Phone Number	
3	E-Mail Address	

1	Base Hosp. Coordinator Name(If Applicable)	
2	Phone Number	
3	E-Mail Address	

1	QA Manager Name	
2	Phone Number	
3	E-Mail Address	

Section D. EMS Data Collection and Submission Agency

1	Do you use electronic patient care reports (ePCRs)?	YES <input type="checkbox"/> (continue to 2,3) NO <input type="checkbox"/> (continue to 4)
2	If YES, Who is your software vendor?	
3	If YES, What is the product name & version?	
4	If NO, When you will start using electronic patient care reports?	N/A <input type="checkbox"/>
5	Will your agency send EMS Run Data to the Bureau of EMS & Trauma System?	YES <input type="checkbox"/> NO <input type="checkbox"/>

1	Does your EMS agency currently have a Quality Assurance Program?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2	If Yes to E.1, please attach copies of your agency's QA process, and copies of approved policies that encompass 100% review of the four clinical areas: ST-elevation MI, Major Trauma, Stroke, and Out-of-Hospital Cardiac Arrest.	
3	Would you like assistance from the BEMSTS in establishing a QA process?	YES <input type="checkbox"/> NO <input type="checkbox"/>

I, the undersigned, as the Senior Manager for the named Agency listed in Section A.1 above herein this application agree to promote the quality assurance process within my agency. I will ensure that there exists a Quality Assurance Committee that meets at least quarterly and that I or my designee will attend. I further agree to ensure that written policies and procedures are produced, put in place, and followed that document the quality assurance process and include the four clinical areas: ST-elevation MI, Major Trauma, Stroke, and Out-of-Hospital Cardiac Arrest. If my agency utilizes an Administrative Medical Director responsible for the care provided by my agency, I will seek his/her participation in the quality assurance process. I will further ensure continued efforts toward achieving the four components necessary to be recognized as a Participant Agency in the BEMSTS Premier EMS Agency Program. I understand that the Premier EMS Agency Program is voluntary and non-punitive. I agree with the established mission of the program, which is to promote evidence-based treatments and integrated quality assurance process of the Arizona EMS and Trauma System to provide the best care for the citizens and visitors of Arizona.

Senior Manager Signature	
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Printed Name:		Date:
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Printed Name:		Date:
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Thank you for applying to participating in the Premier EMS Agency Program. You will be contacted by a BEMSTS staff member via email within two weeks of the BEMSTS receiving your completed and signed application and signed Data User Affirmation Agreement to provide your ADHS-assigned Username and Password and the *Health Services Gateway Manual for PEAP Participants*.

[illegible]